MUST BE PRINTED ON AGENCY LETTERHEAD

ATTACHMENT 13

INVOICE FORMAT

EXHIBIT

OA Tracking #:

OA Date Stamp

1
Contractor Name

Mailing Address
2

3 4
Contract Number/MOU Number

6
Period of Service (month / year)

Program Name: 5

		Amounts
A.	PERSONNEL	$
B.	OPERATING EXPENSE	$
C.	CAPITAL EXPENDITURES . . .	$
D.	OTHER COSTS	$
E.	INDIRECT COSTS	$
TOTAL INVOICE	. . . . .	$ -
(LESS ADVANCE PAYMENT - if applicable)	. .	$ -
TOTAL AMOUNT PAYABLE	. . . . .	**$ -**

I hereby certify that the amount claimed is accurate and a true representation of the amount owed.

7
Authorized Signature

8
Date

Print name of authorized signature

Title

OA Review:

(Initial & Date)

FOR OA USE ONLY

9

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Office of AIDS
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Sacramento, CA 95814